North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

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Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

Michael Moseley, Director

May 17, 2005

MEMORANDUM

To:

Legislative Oversight Committee Members
Commission for MH/DD/SAS
State Consumer/Family Advisory Committee Chairs
Advocacy Organizations and Groups
North Carolina Association of County Commissioners
County Managers
County Board Chairs
North Carolina Council of Community Programs
State Facility Directors
Area Program Directors
Area Program Board Chairs
DHHS Division Directors
Provider Organizations
MH/DD/SAS Professional Organizations and Groups
MH/DD/SAS Stakeholder Organizations and Groups
Other MH/DD/SAS Stakeholders

From: Mike Moseley

Re: **Communication Bulletin #040**
Service Transition Guidance – How to Use Existing Definitions in Transition:
Intensive In Home Services for Children

We know communities are actively engaged in service delivery planning during this time of transition to the new and modified Enhanced services. As we make plans for full implementation of the new services, we are preparing to offer guidance on how some of the most critical of the new services may be offered and reimbursed during the transition period by combining existing service definitions and billing codes. This is the first of three guidance documents that will be issued. This communication contains information on how Intensive In-Home services for children may be delivered and billed during the transition. In subsequent documents we will outline how Community Support for Children and Adults and Mobile Crisis Team services may be implemented in advance of the full implementation of the amended Medicaid State Plan.

Thank you for your efforts to facilitate a smooth and coordinated transition for implementing the best possible array of services and supports for consumers and families in your communities. In addition, we encourage continued participation in training opportunities for trainers and providers. Please contact Dr. Michael Lancaster at (919) 733-7011 or via electronic mail at Michael.Lancaster@ncmail.net if you have questions.

Attachments

cc: Secretary Carmen Hooker Odom
Allyn Guffey
Dan Stewart
DMH/DD/SAS Staff
DMH/DD/SAS Executive Leadership Team
Carol Duncan Clayton
Coalition 2001 Chair
Rob Lamme
Rich Slipsky
Kaye Holder
Wayne Williams
Dick Oliver
Patrice Roesler
Carol Shaw

Transition Plan for Intensive In-Home Service

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the Division of Medical Assistance are proposing a transition plan to begin to develop community capacity in intensive in-home services that will reflect the bundled services available under the new definition pending approval at the Centers for (CMS). This transition plan will allow for billing of intensive in-home using existing service codes as a way to provide this service until the new definition is in place. The following guidelines and definitions are provided to support and encourage Local Management Entities and providers to combine allowable expenditures of state and federal service funds, including Comprehensive Treatment (CTSP) UCR and Non-UCR funds *for in-home child and family services*. These funds should be utilized in supporting activities intended to seamlessly extend, but not conflict with, supports provided through Medicaid, Health Choice, or other public or private funding.

There has been an over-reliance on the residential levels of care in North Carolina. This has been, in part, due to lack of available community resources. The new service definitions using an intensive in-home model of care and a per diem rate will be an important step in developing community resources to support children in their homes and in their communities. We are proposing that each LME begin to review the adolescent and child consumers currently served in residential programs, and determine if a discharge plan can be put in place using the intensive in-home supports discussed here. The goal will be to develop intensive in-home supports in each community using the transition plan described while the new service definition is being approved by CMS. In this fashion, we can begin to develop these community resources NOW.

Included in this transmittal are the following information:

1. **The proposed new service definition for intensive in-home that has been sent to CMS for approval. While this is not THE final definition, it is not expected to have significant changes. Programs should use this definition as a model for developing in-home services in the community.**
2. **An Excel spreadsheet that includes the approximate numbers of adolescent and child consumers, listed by county of residence, who are currently placed in Level 3, 4, and PRTF programs. LMEs should review each case individually to determine if the child could be appropriately served in a less restrictive setting using intensive in-home services. Following this case by case review, programs should evaluate whether there is sufficient need to develop intensive in-home programming as a part of the community continuum.**
3. **For the coverage of this service under Medicaid, a copy of the Outpatient Treatment Report from ValueOptions and instructions for filling it out are included. This OTR can be completed to request pre-certification and ongoing reviews of intensive in-home under existing service codes. ValueOptions has added a separate area for Intensive In-Home Therapy services. These codes can be billed as a bundled service to create the intensive in-home service model during the transition period. Note: There MUST be pre-certification by ValueOptions for this service. Services that are currently authorized by the LME and paid through IPRS may also be included in the service provision as below. This bundled service may require both ValueOptions and LME authorization.**

Service definition	Billing codes	
Screening	LME responsibility	
Evaluation	96100, 96110,96111, 90801, H0001,H0004, H00031,	
Crisis services	YM450	
Case management	T1017 HE	
Outpatient	H0004 HQ/HR/HS,	
Individual Therapy	90804-90809, 90816-90822	
Family Therapy	90846-90847	
Group Therapy	90849, 90853, 90857	
Community Psychiatric Supportive Treatment (Community Based Services)	H00036, H00036HI/HM/HQ/TL/U1	
On-call 24/7		
Respite-**state funds only**	YA125, YA213, YP730	

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Intensive In-Home Services
Medicaid Billable Service

Service Definition and Required Components

This is a time-limited intensive family preservation intervention intended to stabilize the living arrangement, promote reunification or prevent the utilization of out-of-home therapeutic resources (i.e., psychiatric hospital, therapeutic foster care, residential treatment facility) for the identified youth through the age of 20. These services are delivered primarily to children in their family's home with a family focus to:

1. Diffuse the current crisis, evaluate its nature, and intervene to reduce the likelihood of a recurrence;
2. Ensure linkage to needed community services and resources;
3. Provide self help and living skills training for youth;
4. Provide parenting skills training to help the family build skills for coping with the youth's disorder;
5. Monitor and manage the presenting psychiatric and/or addiction symptoms; and
6. Work with caregivers in the implementation of home-based behavioral supports. Services may include crisis management, intensive case management, individual and/or family therapy, substance abuse intervention, skills training, and other rehabilitative supports to prevent the need for an out-of-home, more restrictive services.

This intervention uses a team approach designed to address the identified needs of children and adolescents who are transitioning from out of home placements or are at risk of out-of-home placement and need intensive interventions to remain stable in the community. This population has access to a variety of interventions twenty four (24) hours a day, seven (7) days per week by staff that will maintain contact and intervene as one (1) organizational unit.

Team services are individually designed for each family, in full partnership with the family, to minimize intrusion, and maximize independence. Services are generally more intensive at the beginning of treatment and decrease over time as the youth and family's coping skills develop.
The team services are structured and delivered face-to-face to provide support and guidance in all areas of functional domains: adaptive, communication, psychosocial, problem solving, behavior management, etc. This service is **not** delivered in a group setting.

A service order for Intensive In-Home services must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Intensive In-Home services must be delivered by practitioners employed by a mental health/substance abuse provider organization that meets the provider qualification policies and procedures established by DMH and the requirements of 10A NCAC 27I.0208 (Endorsement of Providers). These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by either being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

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Intensive In-Home Service providers must have the ability to deliver services in various environments, such as homes, schools, detention centers and jails (state funds only), homeless shelters, street locations, etc.

Organizations that provide Intensive In-Home Services must provide "first responder" crisis response on a 24/7/365 basis to recipients who are receiving this service.

Staffing Requirements

This service model includes both a licensed professional and a minimum of two (2) staff who are APs or provisional licensed and who have the knowledge, skills, and abilities required by the population and age to be served. The licensed professional is the team leader is responsible for coordinating the initial assessment and developing the youth's Person Centered Plan (PCP). The service model requires that in-home staff provide 24 hour coverage, 7 days per week. The licensed professional is also responsible for providing or coordinating (with another licensed professional) treatment for the youth or other family members. All treatment must be directed toward the eligible recipient of in-home services. Team to family ratio shall not exceed one to eight (1 to 8) for each three-person team. Intensive In-Home Services focused on substance abuse intervention must include a CCS, CCAS, or CSAC on the team.

Persons who meet the requirements specified for qualified professional or AP status according to 10A NCAC 27G.0104 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver Intensive In-Home Services within the requirements of the staff definition specified in the above rule. Supervision is provided according to supervision requirements specified in 10A NCAC 27G.0104 and according to licensure and certification requirements of the appropriate discipline.

All staff must complete the intensive in-home services training within the first 90 days of employment.

Service Type/Setting

Intensive In-Home services are direct and indirect periodic services where the team provides direct intervention and also arranges, coordinates, and monitors services on behalf of the recipient. This service is provided in any location. Intensive In-Home services are primarily provided in a range of community settings such as recipient's home, school, homeless shelters, libraries, etc. Intensive In-Home services also include telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting their goals specified in their Person Centered Plan.

Note: For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions or for patients in facilities with more than 16 beds that are classified as Institutions of Mental Diseases.

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Clinical Requirements

For Intensive In-Home recipients, a minimum of twelve (12) contacts must occur within the first month. For the second and third months of Intensive In-Home services, an average of six (6) contacts per month must occur. It is the expectation that service frequency will be titrated over the last two (2) months.

Units will be billed on a per diem basis with a minimum of 2 hours per day

Services are primarily delivered face-to-face with the consumer and/or family and in locations outside the agency's facility. The aggregate services that have been delivered by the agency will be assessed annually for each provider agency using the following quality assurance benchmarks:

- Sixty percent (60%) of the contacts occur face-to-face with the youth and/or family. The remaining units may either be phone or collateral contacts; and
- Sixty percent (60%) or more of staff time must be spent working outside of the agency's facility, with or on behalf of the recipients.

Utilization Management

Authorization by the statewide vendor or the LME is required. The amount, duration, and frequency of the service must be included in a recipient's Person-Centered Plan. Initial authorization for services may not exceed thirty (30) days. Reauthorization will occur every sixty (60) days thereafter and is so documented in the Person Centered Plan and service record.

A maximum of thirty-two (32) units of Intensive In-Home Services can be provided in a twenty-four (24) hour period. No more than 360 units of services can be provided to an individual in a three (3) month period unless specific authorization for exceeding this limit is approved.

Entrance Criteria

A recipient is eligible for this service when:

A. There is an Axis I or II diagnosis present, other than a sole diagnosis of Developmental Disability.

AND

B. Treatment in a less intensive service (e.g., community support) was attempted or evaluated during the assessment but was found to be inappropriate or not effective.

AND

C. The youth and/or family have insufficient or severely limited resources or skills necessary to cope with an immediate crisis.

AND

D. The youth and/or family issues are unmanageable in school based or behavioral program settings and require intensive coordinated clinical and positive behavioral interventions.

AND

E. The youth is at risk of out-of-home placement or is currently in an out–of-home placement and reunification is imminent.

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Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the youth's Person Centered Plan or the youth continues to be at risk for out-of-home placement:

A. Recipient has achieved initial Person Centered Plan goals and additional goals are indicated.

AND

B. Recipient is making satisfactory progress toward meeting goals.

AND

C. Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.

OR

D. Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions.

OR

E. Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

Discharge Criteria

Service recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

A. Recipient has achieved goals; discharge to a lower level of care is indicated, or recipient has entered a Substance Abuse Intensive Out-Patient Program.
B. The youth and families/caregivers have skills and resources needed to step down to a less intensive service.
C. There is a significant reduction in the youth's problem behavior and/or increase in pro-social behaviors.
D. The youth's or parent/guardian requests discharge (and is not imminently dangerous to self or others).
E. An adequate continuing care plan has been established.
F. The youth requires a higher level of care (i.e., inpatient hospitalization or PRTF).

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Documentation Requirements

Minimum standard is a shift note for every eight hours of services provided that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions and the signature of the staff providing the service.

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Expected Outcomes

The individual's living arrangement has been stabilized, crisis needs have been resolved, linkage has been made with needed community service/resources; youth has gained living skills; parenting skills have been increased; need for out of home placements has been reduced/eliminated

Service Exclusions/Limitations

An individual can receive Intensive In-Home Services from only one Intensive In-Home provider organization at a time.

Intensive in-home services cannot be provided during the same authorization period with the following services except as specified below. Community Support or living in a Level II-IV child residential or substance abuse residential facility

Service Limitation: Intensive in-home services can be billed for a maximum of 8 units per month in accordance with the person centered plan for individuals who are receiving the services listed above for the purpose of facilitating transition to the service, admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the CS professional and discharge planning.

Multisystemic Therapy, Day Treatment, Hourly Respite, individual, group or family therapy or SAIOP cannot be billed while an individual is receiving Intensive In-Home Services.

Persons by county and month of service

Residential Level Level 3+4+PRTF Treatment.

Service in April 2004 through March 2005 paid through March 2005: Medicaid, IPRS (including fiscal denials) and Health Choice

Does not include adjustments. Note that some the lag between service date and payment date will affect more recent months as providers have one year to bill.

Adam Holtzman, DMH/DD/SAS RRM (919) 715-7774

April 28, 2005

Service Group	county	county name	Apr-04	May-04	Jun-04	Jul-04	Aug-04	Sep-04	Oct-04	Nov-04	Dec-04	Jan-05	Feb-05	Mar-05
LVL-3,4,PRTF	.	unknown	0	0	1	1	1	2	1	2	2	0	0	0
LVL-3,4,PRTF	1	ALAMANCE	24	20	17	19	17	19	22	25	22	17	16	12
LVL-3,4,PRTF	2	ALEXANDER	3	3	3	3	3	3	3	3	3	2	3	2
LVL-3,4,PRTF	3	ALLEGHANY	0	0	0	0	0	1	1	1	1	1	1	0
LVL-3,4,PRTF	4	ANSON	23	22	24	23	23	26	26	27	28	23	20	9
LVL-3,4,PRTF	5	ASHE	2	2	3	3	4	5	5	4	3	1	1	1
LVL-3,4,PRTF	6	AVERY	2	2	3	4	4	2	3	2	4	3	4	0
LVL-3,4,PRTF	7	BEAUFORT	20	21	21	20	19	19	21	22	20	21	18	12
LVL-3,4,PRTF	8	BERTIE	3	2	0	0	0	0	2	3	3	4	3	2
LVL-3,4,PRTF	9	BLADEN	10	11	8	3	3	5	4	5	5	4	4	4
LVL-3,4,PRTF	10	BRUNSWICK	12	15	14	16	17	18	18	19	19	24	21	15
LVL-3,4,PRTF	11	BUNCOMBE	70	68	72	63	60	52	52	47	47	46	38	24
LVL-3,4,PRTF	12	BURKE	26	26	24	25	23	19	22	24	25	24	19	13
LVL-3,4,PRTF	13	CABARRUS	37	38	36	36	31	40	40	42	46	39	36	25
LVL-3,4,PRTF	14	CALDWELL	21	23	20	23	20	21	25	25	22	21	22	21
LVL-3,4,PRTF	15	CAMDEN	1	0	0	1	1	1	1	1	2	0	0	0
LVL-3,4,PRTF	16	CARTERET	10	12	13	12	10	10	14	16	16	13	13	11
LVL-3,4,PRTF	17	CASWELL	13	11	11	11	11	12	12	10	11	8	8	6
LVL-3,4,PRTF	18	CATAWBA	32	35	31	27	29	28	28	33	32	30	27	16
LVL-3,4,PRTF	19	CHATHAM	9	8	9	12	16	15	14	15	16	14	10	6
LVL-3,4,PRTF	20	CHEROKEE	8	7	8	9	7	7	6	7	7	6	5	2
LVL-3,4,PRTF	21	CHOWAN	8	8	6	4	5	5	6	6	4	4	2	2
LVL-3,4,PRTF	22	CLAY	4	4	4	3	3	3	3	3	3	4	3	2
LVL-3,4,PRTF	23	CLEVELAND	57	54	54	46	48	52	46	44	52	49	42	36
LVL-3,4,PRTF	24	COLUMBUS	10	12	12	14	14	15	11	13	13	13	12	12
LVL-3,4,PRTF	25	CRAVEN	28	27	31	33	32	31	33	31	30	23	24	17
LVL-3,4,PRTF	26	CUMBERLAND	59	71	80	72	72	78	80	76	72	67	61	35
LVL-3,4,PRTF	27	CURRITUCK	4	4	4	4	3	4	5	4	4	4	3	3
LVL-3,4,PRTF	28	DARE	11	11	11	10	10	9	9	9	10	6	3	1
LVL-3,4,PRTF	29	DAVIDSON	37	34	29	28	28	28	32	31	32	28	21	14
LVL-3,4,PRTF	30	DAVIE	8	9	7	6	7	8	8	6	5	1	1	1
LVL-3,4,PRTF	31	DUPLIN	10	9	9	11	8	9	11	10	10	9	8	5
LVL-3,4,PRTF	32	DURHAM	80	80	78	74	74	81	88	90	89	76	71	50
LVL-3,4,PRTF	33	EDGECOMBE	19	19	24	19	16	15	13	13	12	12	13	11
LVL-3,4,PRTF	34	FORSYTH	88	89	101	95	95	89	96	93	91	83	84	52
LVL-3,4,PRTF	35	FRANKLIN	13	15	14	15	16	18	15	14	15	12	13	8
LVL-3,4,PRTF	36	GASTON	114	121	111	108	98	101	105	109	107	102	85	55
LVL-3,4,PRTF	37	GATES	1	1	1	1	0	0	0	0	0	1	1	1
LVL-3,4,PRTF	38	GRAHAM	8	6	6	5	4	5	6	6	4	4	4	3
LVL-3,4,PRTF	39	GRANVILLE	12	14	14	13	14	13	13	14	14	13	12	10
LVL-3,4,PRTF	40	GREENE	5	5	5	5	3	3	3	3	4	3	2	1
LVL-3,4,PRTF	41	GUILFORD	68	76	76	70	73	72	71	77	80	60	57	32
LVL-3,4,PRTF	42	HALIFAX	12	14	10	7	8	9	16	15	14	13	12	4
LVL-3,4,PRTF	43	HARNETT	27	32	28	27	26	24	24	26	30	25	20	15
LVL-3,4,PRTF	44	HAYWOOD	31	32	27	22	25	24	21	24	23	19	14	11
LVL-3,4,PRTF	45	HENDERSON	25	25	23	29	26	25	19	15	16	12	8	6
LVL-3,4,PRTF	46	HERTFORD	8	9	9	11	10	9	8	7	7	6	8	3
LVL-3,4,PRTF	47	HOKE	9	8	8	7	6	6	7	8	10	12	11	6
LVL-3,4,PRTF	48	HYDE	4	4	4	4	4	4	2	3	3	3	3	3
LVL-3,4,PRTF	49	IREDELL	26	26	28	24	23	27	30	32	29	24	20	10

Persons by county and month of service

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LVL-3,4,PRTF	50	JACKSON	6	7	8	9	7	8	7	8	11	8	8	5
LVL-3,4,PRTF	51	JOHNSTON	37	37	37	35	39	42	46	43	41	37	33	16
LVL-3,4,PRTF	52	JONES	2	1	1	0	0	0	0	0	0	0	0	0
LVL-3,4,PRTF	53	LEE	12	14	12	9	8	8	8	9	10	8	9	3
LVL-3,4,PRTF	54	LENOIR	14	14	10	13	13	14	16	16	16	13	13	10
LVL-3,4,PRTF	55	LINCOLN	27	28	28	27	28	28	28	25	26	23	15	10
LVL-3,4,PRTF	56	MACON	6	6	8	7	10	13	12	13	12	10	8	7
LVL-3,4,PRTF	57	MADISON	15	13	14	12	10	10	8	9	12	12	11	7
LVL-3,4,PRTF	58	MARTIN	8	8	9	7	10	10	10	10	9	9	8	7
LVL-3,4,PRTF	59	MCDOWELL	17	19	19	20	22	20	20	20	12	11	11	9
LVL-3,4,PRTF	60	MECKLENBURG	91	88	92	91	95	90	105	103	91	86	67	48
LVL-3,4,PRTF	61	MITCHELL	2	2	3	3	3	3	4	5	4	3	3	2
LVL-3,4,PRTF	62	MONTGOMERY	14	13	11	8	5	7	7	7	6	4	4	3
LVL-3,4,PRTF	63	MOORE	30	30	29	32	34	32	30	32	31	29	28	11
LVL-3,4,PRTF	64	NASH	11	11	10	10	8	8	10	9	10	10	8	4
LVL-3,4,PRTF	65	NEW HANOVER	93	103	102	98	94	94	107	106	108	100	98	51
LVL-3,4,PRTF	66	NORTHAMPTON	8	8	7	7	7	8	8	8	9	7	5	5
LVL-3,4,PRTF	67	ONSLOW	26	26	24	23	23	28	34	34	32	33	24	20
LVL-3,4,PRTF	68	ORANGE	34	39	37	34	33	33	35	34	34	33	26	19
LVL-3,4,PRTF	69	PAMLICO	3	5	3	2	3	4	5	5	5	4	5	3
LVL-3,4,PRTF	70	PASQUOTANK	20	22	21	22	23	24	24	25	22	20	7	5
LVL-3,4,PRTF	71	PENDER	7	8	10	11	12	11	12	13	14	17	15	10
LVL-3,4,PRTF	72	PERQUIMANS	4	3	3	3	3	4	4	5	5	4	0	0
LVL-3,4,PRTF	73	PERSON	23	22	20	15	12	11	12	11	9	9	3	2
LVL-3,4,PRTF	74	PITT	41	44	43	40	40	40	41	43	40	44	42	29
LVL-3,4,PRTF	75	POLK	4	2	3	3	3	3	3	3	3	3	4	4
LVL-3,4,PRTF	76	RANDOLPH	62	70	72	61	60	60	60	58	65	61	59	29
LVL-3,4,PRTF	77	RICHMOND	18	20	19	20	24	24	22	23	26	25	21	12
LVL-3,4,PRTF	78	ROBESON	58	64	68	57	58	65	58	50	49	52	52	45
LVL-3,4,PRTF	79	ROCKINGHAM	46	49	55	48	49	48	51	53	52	44	31	15
LVL-3,4,PRTF	80	ROWAN	40	36	35	33	35	39	36	41	38	39	35	28
LVL-3,4,PRTF	81	RUTHERFORD	27	28	24	27	25	24	28	30	30	27	25	15
LVL-3,4,PRTF	82	SAMPSON	9	9	9	10	11	16	15	15	15	14	12	7
LVL-3,4,PRTF	83	SCOTLAND	24	25	25	25	24	24	20	17	14	13	12	9
LVL-3,4,PRTF	84	STANLY	14	13	10	7	7	8	9	8	8	7	7	5
LVL-3,4,PRTF	85	STOKES	13	12	11	12	12	7	10	11	12	13	10	7
LVL-3,4,PRTF	86	SURRY	12	12	12	12	12	12	15	13	14	12	8	3
LVL-3,4,PRTF	87	SWAIN	6	6	6	6	5	4	2	4	2	1	3	1
LVL-3,4,PRTF	88	TRANSYLVANIA	9	8	6	8	8	9	8	11	9	8	8	5
LVL-3,4,PRTF	89	TYRRELL	1	2	2	2	2	2	2	2	1	1	1	0
LVL-3,4,PRTF	90	UNION	30	31	26	22	17	18	19	21	22	20	20	16
LVL-3,4,PRTF	91	VANCE	9	10	9	7	7	7	9	7	7	10	11	9
LVL-3,4,PRTF	92	WAKE	190	204	207	196	182	194	204	208	214	202	200	139
LVL-3,4,PRTF	93	WARREN	5	6	6	7	6	6	7	6	7	7	7	6
LVL-3,4,PRTF	94	WASHINGTON	6	7	7	6	6	7	7	7	7	6	3	2
LVL-3,4,PRTF	95	WATAUGA	8	7	7	6	6	6	5	7	6	4	4	4
LVL-3,4,PRTF	96	WAYNE	27	29	30	32	32	31	31	33	37	34	30	24
LVL-3,4,PRTF	97	WILKES	14	14	15	8	11	8	7	7	8	6	7	6
LVL-3,4,PRTF	98	WILSON	23	19	17	17	16	16	16	13	20	20	18	12
LVL-3,4,PRTF	99	YADKIN	22	21	21	20	18	18	19	17	16	15	14	11
LVL-3,4,PRTF	100	YANCEY	1	3	5	5	8	8	11	8	7	6	6	4

Persons by county and month of service														
Residential Level Level 3+4+PRTF Treatment.														
Service in April 2004 through March 2005 paid through March 2005: Medicaid, IPRS (including fiscal denials) and Health Choice														
Does not include adjustments. Note that some the lag between service date and payment date will affect more recent months as providers have one year to bill.														
Adam Holtzman, DMH/DD/SAS RRM (919) 715-7774														
April 28, 2005														
Service Group	county	county name	Apr-04	May-04	Jun-04	Jul-04	Aug-04	Sep-04	Oct-04	Nov-04	Dec-04	Jan-05	Feb-05	Mar-05
			2,341	2,423	2,400	2,273	2,236	2,286	2,368	2,381	2,375	2,173	1,946	1,294

ValueOptions

Step-by-Step Instructions for Completing the NC Medicaid Behavioral Health/Substance Abuse Outpatient Treatment Report

Rev 04/21/05

This information pertains to: 1) Area Authorities and Local Management Entities (LME's); 2) Providers who are contracted with a Medical Group, Health Department or other contracting agency; and 3) Direct Enrolled Providers.

Please ensure that each section is completed and legible. Upon completion of the form please fax it to ValueOptions at (919) 941-0433 or mail it to ValueOptions, Inc. P.O. Box 13907, RTP, NC 27709. **PLEASE DO NOT FAX <u>AND</u> MAIL YOUR FORMS** as such duplication may delay your request.

Initial Assessment **Subsequent Assessment**	Please check *Initial Assessment* if this is the first review by ValueOptions or check *Subsequent Assessment* if this is a concurrent review.

PATIENT DEMOGRAPHICS	
Patient's Name	Enter the patient's first, middle and last name.
Date of Birth	Enter the patient's date of birth using month, day, year.
Patient's Medicaid #	Enter the patient's Medicaid number as it appears on their Medicaid ID card. This number is required in order to review the OTR *
Parent/Guardian Name	Enter the legal guardian's full name. If the legal guardian is DSS, enter DSS and Social Worker's name (if known).
Parent/Guardian Address	Enter the legal guardian's complete address. If DSS is legal guardian, enter DSS address.
Parent/Guardian Phone Number: Home/ Work	Enter phone number (if available) for parent or legal guardian. If DSS is legal guardian, enter Social Worker's phone number.
County of Eligibility	Enter the county of the patient's or legal guardian's residence.
Date applied for Medicaid	*If the patient's Medicaid is pending, enter the date of the application for Medicaid on this line. Upon application for Medicaid, DSS enters a Medicaid ID# into the State's Eligibility Information System (EIS). Please enter that number under Patient's Medicaid # above.

ASAM Risk Rating for Substance Abuse (if applicable)	
Dimension I - Dimension VI	Complete as requested using ASAM criteria as basis

Area Authority/LME	Enter the name of the Area Authority/LME providing services to the patient. If Area Authority/LME is NOT providing the services, please leave this line blank.
Contracted Provider of Area Authority/LME	Enter the name of the Contracted Provider. A Contracted Provider is one who is contracted with the Area Authority/LME, bills through the Area Authority/LME and/or uses the Area Authority/LME's Medicaid provider number to bill for services. If the contracted provider is NOT providing the services, please leave this line blank.
Direct Enrolled	Enter the name of the Direct Enrolled Provider providing services to the patient. A Direct Enrolled provider is one who is enrolled directly with Medicaid and uses their own Medicaid Provider number to bill for services. If the Direct Enrolled provider is NOT providing the services, please leave this line blank.
Provider Filing "Incident to"	Enter the name of the MD, PhD or group practice who bills for the services requested. An "incident to" provider is one who is employed by an MD, PhD or group practice and bills for services using the Medicaid Provider number of the MD, PhD or group practice.
Provider Name	Enter the name of the individual practitioner providing the services to the patient.
Provider's Medicaid #	Enter the provider number for the provider who will bill for the services. If solo practice, enter the individual's Medicaid provider #; if provider is in a mental health group practice or is contracted with another entity, enter the Medicaid provider # for the group or entity.
Referring Physician's Name	Services provided to recipients under the age of 21 require a referral by a Carolina ACCESS primary care provider, the Local Management Entity or a Medicaid-enrolled psychiatrist. Recipients over age 21 do not require a referral.
Referring Physician's Provider #	The referring physician must be enrolled with DMA. Please enter the referring physician's Medicaid Provider # in this space (it may or may NOT be the same as the referral number below). This field is only required if the patient is under age 21.

SERVICE PROVIDER DEMOGRAPHICS (continued)	
Federal Tax ID Number	Enter the billing Provider's Federal Tax ID Number.
Referral #	Enter referring physician's 7 digit referral #. This number is Required for all Direct Enrolled providers for recipients under 21 years of age. A referral number is not required for recipients age 21 and older.
Address	Enter the complete address and phone number (including area code) where patient receives treatment.

MEDICATIONS	
Medications	1) Check whether or not patient has been evaluated for medications, and 2) check whether or not patient follows medication regimen.
Prescribing Physician	Enter physician's name and also indicate if physician is the Primary Care Physician (PCP) or Psychiatrist.
Name of Medications	Enter name of medication, current dosage/frequency, the date the patient began taking the medication and check whether or not the patient is experiencing side effects.
Describe side effects/ Interventions	If you checked *Yes* under side effects, please enter the side effect and what steps have been taken to remedy or lessen the side effect (if any).

ASSESSMENT	
Symptoms	Look down the list of symptoms and for any symptoms that pertain to the patient, enter a rating on the line next to the applicable symptom (S=Same, B=Better, W=Worse). All blank lines are assumed to be absent. If you check *Other*, please write out the symptom and rate it as above.

DIAGNOSES

ICD-9 DX_____: **Axis I:_____-** **____;_____; _____**	Enter the ICD-9 diagnoses (It is okay to use the DSM-IV codes) AND the Axis I diagnoses (Required for Claims Payment)
Axis II: **Axis III:** **Axis IV:**	Enter the diagnoses for Axis II-IV if available
Axis V: Current GAF or CAFAS	Enter the Current diagnoses and either the GAF or CAFAS (required)
Current Risk Assessment	Please check all the risk assessments that apply to patient.
Crisis Plan in Place	Check whether or not a crisis plan is in place and the date of the risk assessment.
Other risk behaviors	Enter any other risk behaviors currently present.
Last contact to coordinate	Enter the last date (via phone, letter, or face-to-face) you coordinated treatment for behavioral care and medical care (meaning coordination of care between any mental health and enter the last date you worked on coordinating treatment for medical care (i.e. with a primary care physician). If no coordination of care has occurred, please write "none" in the date area.

Treatment Type & Frequency & Duration

Date First Seen	The date the patient was *FIRST* seen by the Area Authority/LME or Contracted Provider for the current condition for which they are being treated.
Date Last Seen	The date the patient was *LAST* seen by the Area Authority/LME or Contracted Provider for the current condition for which they are being treated.
Psychotherapy	Choose the applicable treatment (Individual, Group or Family). Please enter the specific CPT code(s) for each of the services being requested. CPT codes count as one visit.

Treatment Type & Frequency & Duration (continued)	
Behavioral Counseling	**For the following codes that are billed in 15 minute increments: H0031, H0001, H0004 (modifiers are not necessary) and H0005, the actual H code must be specified along with the number of 15 minute increments necessary to provide the requested service(s) in order to ensure prompt claims payment. (examples: 1hr = 4 units requested, 2hrs = 8 units requested)**
SA IOP	For LME's Only, please note that Intensive Outpatient Treatment (H0015) will be done telephonically for initial and concurrent reviews. **Please call ValueOptions at 1-888-510-1150. NOTE: Direct Enrolled Providers may NOT bill H0015.**
Intensive In-Home Therapy Services	If you are requesting authorization for Intensive In-Home Therapy services, please call ValueOptions at 1-888-510-1150.
# Visits Requested	Print the number of visits you are requesting for each treatment. Please ensure that you check eligibility (particularly end dates) as providers are responsible for verifying Medicaid eligibility.
Frequency	Enter the frequency of treatment for treatment type (i.e. number of visits/days per week; number of visits/days per month, etc.) as applicable.
Estimated End Date	Enter the date the provider anticipates treatment to end.
CASA Works Perinatal/Maternal Methadone Maintenance	Check applicable box.
Treating Provider's	Enter the name of the person who knows the most about the patient's current condition and treatment plan and the person responsible for answering clinical questions about the patient.
Credentials	Enter the credentials (i.e. MD, LCSW, PhD, LPC, LMFT, CNS, CCS, CCAS) of the Treating Provider.
Phone #	Enter the phone number including area code where the Treating Provider can be reached during working hours 8am to 6pm.
Date	Enter the date the form is completed.

Service Orders	
Service Orders	Service Orders must be submitted to VO along with the OTR for **all** Medicaid recipients for all Direct Enrolled providers before the 26th visit for individuals under age 21 and before the 8th visit for individuals age 21 and older. If a Service Order is NOT received with the OTR, the OTR will be returned as incomplete. Please ensure the recipient's name, Medicaid ID# and provider information is on the Service Order. Service Orders are valid for the duration of the order (if a date is specified) or until the end of each year. Exception: Medical Doctors, licensed Psychologists (doctorate level), Nurse Practitioners and Physician's Assistants are not required to submit Service Orders.
Reminders	ValueOptions will authorize the services beginning with the date the completed OTR is received in our office (assuming the services meet NC Medicaid's medical necessity criteria). The 26 unmanaged visits for recipients under age 21 and the 8 unmanaged visits for recipients age 21 and older begin again each calendar year. **If you have any questions regarding completion of the OTR please contact Mary Simpson or Connie Kelly at 1-888- 510-1150.**

ValueOptions

NC MEDICAID BEHAVIORAL HEALTH/SUBSTANCE ABUSE OUTPATIENT TREATMENT REPORT

Rev 04/21/05

ValueOptions, Inc.
P.O. Box 13907
RTP, NC 27709-3907
Phone# 888-510-1150
Fax# 919-941-0433

☐ **Initial Assessment** ☐ **Subsequent Assessment**

PATIENT DEMOGRAPHICS

Patient's Name _____

Date of Birth ____/____/____

Age _____ Gender _____ Patient SS# _____

Patient's Medicaid # _____

Parent/Guardian Name _____

Patient or Parent/Guardian Address _____

City _____ State _____ Zip Code _____

Patient/Guardian Phone Number: Home (_____)_____

County of Eligibility_____ Work (_____)_____

If Medicaid eligibility is pending: Contact County DSS for ID# and date applied for Medicaid _____/_____/_____

SERVICE PROVIDER DEMOGRAPHICS

Please Read the Instructions Before Completing this Section:

☐ Area Authority/LME: _____

☐ Contracted Provider of Area Authority/LME:_____

☐ Provider Directly Enrolled with Medicaid:_____

☐ Provider Filing "Incident to": _____

Provider Name _____(indiv providing service)

Provider's Medicaid #_____(for billing)

Referring Physician's Name_____(if patient is under 21)

Referring Physician's Provider #_____

Fed Tax ID#_____ Referral # ___ ___ ___ ___ ___ ___ ___

Address Where Services Rendered _____

City _____ State _____ Zip Code_____

Phone number: (___ ___ ___) - ___ ___ ___ -- ___ ___ ___ ___

ASAM Risk Rating for Substance Abuse

(If applicable)

A higher risk rating indicates greater level of severity and/or intensity

Dimension:	Risk Rating: Circle		
1. Withdrawal/Intoxication …….. ……	Low	Moderate	High
2. Medical Complication……	Low	Moderate	High
3. Behavioral/Emotional/Cognitive Complication ….	Low	Moderate	High
4. Readiness for Change (Low Readiness = High Risk)…	Low	Moderate	High
5. Relapse/Continued use or problem potential……	Low	Moderate	High

If relapsed, when/frequency _____

Response to Tx during unmanaged visits portion (circle):

Abstinence Controlled use Periods of sobriety

6. Recovery Environment ……Low Moderate High

MEDICATIONS (list all psychotropic and other medications)

Has patient been evaluated for medications? Yes ☐ No ☐

Does patient follow medication regimen? Yes ☐ No ☐

Prescribing physician (indicate if PCP or Psychiatrist):

_____

Medications	Current Dosage/Freq.	Start Date	Side Effects
_____			Yes ☐ No ☐
_____			Yes ☐ No ☐
_____			Yes ☐ No ☐

Describe side effects/interventions: _____

Patient's Name_____ **Medicaid ID#**_____

ASSESSMENT

SYMPTOMS: *Please rate symptoms response to treatment*

(S=Same, B=Better, W=Worse) Those not rated will be assumed absent

____Guilt ____ Hyperactivity ____ Obsession/Compulsions

____Anxiety ____ Irritability ____ Depressed Mood

___Panic Attacks ___ Hopelessness ___ Decreased Energy

____Grief ____ Impulsiveness ___ Elevated Mood

____Delusions ____ Hallucinations ____ Dissociative States

____Paranoia ____ Worthlessness ____ Active Substance

____Somatic Complaints ____Emotional/Physical/Sexual Trauma Victim

_____Medical Condition ____Emotional/Physical/Sexual Trauma Perpetrator

_____Other

DIAGNOSIS

ICD-9 DX _____

Axis I: _____- _____; _____ - _____

Axis II: _____-_____; _____-_____

Axis III: _____-_____; _____-_____

Axis IV:_____

Axis V: Current GAF _____ OR CAFAS _____

Other risk behaviors:

_____

_____

Last contact to coordinate treatment:

Behavioral _____/_____/_____

Medical _____/_____/_____

Current Risk Assessment: *(Check all that apply)*

Suicidality: ☐ Not Present ☐ Ideation ☐ Plan ☐ Means ☐ Prior Attempt

Homicidality: ☐ Not Present ☐ Ideation ☐ Plan ☐ Means ☐ Prior Attempt

Crisis plan in place: Yes ☐ No ☐

Date of Risk Assessment ____/____/____

TREATMENT TYPE & FREQUENCY & DURATION:

Date first seen: _____/_____/_____ Date last seen: _____/_____/_____ ☐Casa Works ☐Perinatal/Maternal

☐Methadone Maintenance

Treatment	#Visits/#Days	Frequency (#vs/wk., mo., or #days/wk. etc.)	Estimated End Date
PSYCHOTHERAPY: (CPT)			
Individual:			
Group:			
Family:			

CPT codes are counted as visits

Behavioral Counseling: (H Codes)	Indicate the appropriate H code along with the number of 15 min increments requested		
Individual:			
Group:			
Family:			

H codes are counted as unit (1 unit = 15 min)
examples:
1hr. = 4 units **1½ hrs. = 6 units**

Intensive In-Home Therapy Srvcs ☐ **For Precertification and concurrent reviews please call ValueOptions 1-888-510-1150**

SA IOP H0015 ☐ **For Precertification and concurrent reviews please call ValueOptions 1-888-510-1150 (For LME's only)**

Treating Provider's Name:_____ _____ **Credentials**_____
(Print Name) **(Signature)**

Phone #: (**)**_____ **Date** _____ **This form can be downloaded from : www.valueoptions.com**

☐ **Service Order Attached (required for all direct enrolled providers except MD's, PhD's, NP's)**

Rev. 04/21/05